COE FAMILY VISION CLINIC - REGISTRATION FORM

PATIENT INFORMATION

Patient's last name:	First:	Middle	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / part / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	City:	State:	Zip Code:

Home phone # :( )	Cell# :( )	What is the Best way to reach you?

E-mail Address:	When is the best time to reach you?

Occupation:	Employer:	Employer phone no.: ( )

Referred to clinic by (please check one box):	❑ Dr.	❑Internet	❑ Insurance Plan	❑ Hospital

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

INSURANCE INFORMATION

Medical Insurance

Person responsible for bill:	Sub scriber Birth date: / /	Address (if different):	Home phone no.: ( )

Occupation:	Employer:	Employer phone no.:

Please indicate primary Medical insurance	❑ Medicare	❑ Medicaid	❑ Regence Blue shield	❑ Premera Blue Cross	❑First Choice health

❑ United Health Care	❑ VSP	❑ Aetna	❑ Medical Coupon *(Please provide coupon)*	❑ Other

Subscriber's name:	Subscriber's S.S./ID #:	Birth date :mm/dd/year:

Group no.:	Policy no.:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

VISION INSURANCE IF DIFFERENT THEN MEDICAL INSURANCE.

Name of Vision Insurance (If other then Medical)?	Subscriber's name:	ID #:	Group #:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone #: ( )	Work phone #: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Coe Family Vision Clinic or insurance company to release any information required to process my claims.

Patient/Guardian Signature ____ Date:____________________________

HEALTH HISTORY QUESTIONNAIRE

All Information contained in this questionnaire are strictly confidential and will become part of your **medical record.**

Name(Last, First, M.I.)

CURRENT DOCTOR:	PHONE #:	DATE OF LAST PHYSICAL EXAM:

Date of Last Eye Exam:

Occupation:

PERSONAL HEALTH HISTORY

Do You Currently Have Or Had Any Of The Following Conditions?				
	☐Diabetes Type:	☐ Thyroid Problem	☐ Respiratory Problems	☐ Blood Disorders
	☐ Hypertension	☐ Anxiety	☐ Stroke/Neurological	☐ Hepatitis
	☐Cancer	☐ Depression	☐ Cardiovascular Problems	Other (Please Explain):
	☐Arthritis/Rheumatoid	☐Tuberculosis	☐HIV/AIDS	

Have You Ever Been Treated For Or Diagnosed With Any Of The Following?		
☐Cataracts	☐Strabismus/Crossed Eye	☐Eye Infection
☐Amblyopia/Lazy Eye	☐Retinal Problems	☐Eye Surgery
☐Glaucoma	☐Macular Degeneration	☐Eye Trauma

Do You Have A Family History Of The Following?	
☐Diabetes	☐Glaucoma
☐Macular Degeneration	Other(Please Explain):
☐Blindness	

Do You Experience Any Of The Following?

☐Flashes of Light	☐Double Vision	☐Blurred Vision
☐Floaters	☐Light Sensitivity	☐Itching/ Burning/ Dryness
☐Eye Pain	☐Tearing	Other(Please Explain):
☐Redness	☐Unexplained Headaches	

SURGERIES	YEAR	REASON

LIST YOUR PRESCRIBED DRUGS. PLEASE INCLUDE OVER-THE-COUNTER MEDICATION AND SUPPLEMENTS THAT ARE TAKEN REGULARLY.

ALLERGIES TO MEDICATIONS

HEALTH HABITS AND PERSONAL SAFETY

Alcohol	Do you drink alcohol? ☐yes ☐No	How many drinks per week?
Tobacco	Do you use tobacco? ☐yes ☐No	☐ Cigarettes☐Chew ☐ Pipe ☐ Cigars #per day? ______#of years:________ Or year quit____
Drugs	Do you currently use recreational or street drugs? ☐yes ☐No	Have you ever given yourself drugs with a needle?
Women Only	Are you pregnant or breastfeeding? ☐yes ☐No	